General Imaging Order Form

OREGON IMAGING CENTERS

TODAY'S DATE: _____

General Scheduling: (541) 334-7555 • TF: (888) 968-7608
Fax Orders: (541) 334-7564
Online Orders: forms.oregonimaging.com/general-order-form

SPECIAL REPORTING/SCHEDULING INSTRUCTIONS

☐ ASAP Scheduled

**As an outpatient only facility we do not perform true STAT exams, if the need is emergent please consider referring patient to an Emergency Department or Urgent Care facility.*

Patient Last Name (Required) First Middle	Date Of Birth (Required) Patient Daytime Phone
Ordering Clinician (Required - Please Print) Office Location (If Multiple)	Clinician Signature (Required - No Stamps) Date
Insurance PA#	Send Additional Copies Of Report To
Symptoms / Diagnosis / History (Required) - Include Icd-Code(S)	

If the exam you need is not listed, please choose the modality and write in the exam description.

☐ X-Ray ☐ Fluoro/Diagnostics ☐ MRI ☐ MRA ☐ CT ☐ CTA ☐ US Exam Description: _____

X-RAY No appointment neccesary

- ☐ Skull
- ☐ Sinus ☐ 1V ☐ 3View
- ☐ Facial Bones
- ☐ Chest 1 View (Positive PPD)
- ☐ Chest 2 Views
- ☐ Ribs w/PA Chest ☐ L ☐ R
- ☐ Ribs w/PA Chest & LAT Chest ☐ L ☐ R
- ☐ Abdomen (KUB)
- ☐ Abdomen 2 View w/ CXR ☐ PA ☐ PA/LAT
- ☐ Bone/Skeletal Survey (Scheduled Exam)
- ☐ Sacroiliac Joints
- ☐ Pelvis

SPINE

- ☐ C-Spine (choose one)
  ☐ Ltd ☐ W/Obl ☐ W/Flex/Ext
- ☐ T-Spine
- ☐ L-Spine ☐ W/Obl ☐ W/Flex/Ex
- ☐ Thoracolumbar 2V
- ☐ Scoliosis Survey
- ☐ Sacrum & Coccyx

EXTREMITY

	L	R	
☐ Shoulder	☐	☐	
☐ Humerus	☐	☐	
☐ Clavicle	☐	☐	
☐ Elbow	☐	☐	
☐ Forearm	☐	☐	
☐ Wrist	☐	☐	
☐ Hand	☐	☐	
☐ Femur	☐	☐	
☐ Knee	☐	☐	☐ Sunrise
☐ Tib/Fib	☐	☐	
☐ Ankle	☐	☐	
☐ Foot	☐	☐	
☐ Calcaneus	☐	☐	
☐ Fingers Digit#___	☐	☐	
☐ Toes Digit#___	☐	☐	
☐ Hip Unilateral with Pelvis	☐	☐	
☐ Hip Bilateral with Pelvis			
☐ Hands & Wrists Arthritis Survey			

FLUORO / DIAGNOSTICS

☐ Joint Injection ☐ L ☐ R
Specify joint(s) and list medications
_____

☐ Joint Aspiration ☐ L ☐ R
Specify joint(s) to be aspirated *Lab Order Required
_____

PET / CT

Special order form required, call (541) 334-7576

MRI

Contrast Choice

- ☐ **At Radiologist's Discretion**
- ☐ WO ☐ W/WO ☐ W (rare exam)
- ☐ Brain
- ☐ Brain Attention Orbits
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Breast (See Breast Imaging Section)
- ☐ Pelvis
- ☐ Pelvis for Sacrum/Coccyx

	L	R
☐ Abdomen		
☐ Shoulder	☐	☐
☐ Elbow	☐	☐
☐ Wrist	☐	☐
☐ Hip	☐	☐
☐ Knee	☐	☐
☐ Ankle	☐	☐
☐ Foot	☐	☐

- ☐ Arthrogram (Specific) Site _____

MR ANGIOGRAM

- ☐ Brain (Circle of Willis)
- ☐ Neck (Carotids)
- ☐ Chest
- ☐ Abdomen
- ☐ Pelvis _____

CT

Contrast Choice

- ☐ **At Radiologist's Discretion**
- ☐ WO ☐ W/WO ☐ W
- ☐ Brain
- ☐ Sinus ☐ Complete ☐ Limited
- ☐ Maxillofacial
- ☐ Neck Soft Tissue
- ☐ Chest
- ☐ Lung Screening ☐ Shared Decision Making
- ☐ Heart Calcium Scoring
- ☐ Abdomen (Specific Organ) _____
- ☐ Abdomen/Pevis
- ☐ KUB (Abdomen/Pelvis for Stones)
- ☐ Pelvis
- ☐ C-Spine
- ☐ T-Spine
- ☐ L-Spine
- ☐ Myelogram (Specific Site)
- ☐ Upper Ext – Site _____ ☐ L ☐ R
- ☐ Lower Ext – Site _____ ☐ L ☐ R
- ☐ Arthrogram – (Specific) _____ ☐ L ☐ R

CT ANGIOGRAM

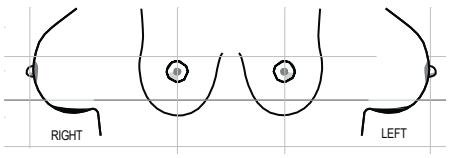
- ☐ CTA-Brain
- ☐ CTA-Neck
- ☐ CTA-Chest
- ☐ CTA-Chest for PE
- ☐ CTA-Renal
- ☐ CTA-Abdomen with Pelvis
- ☐ CTA-Abdomen with Runoff

ULTRASOUND / DOPPLER

- ☐ Thyroid
- ☐ Soft Tissue Specify Site: _____
- ☐ Carotid Doppler
- ☐ AAA Doppler (Symptomatic) AAA
- ☐ AAA Doppler (Asymptomatic) AAA
- ☐ Abdomen complete with Portal Vein Doppler
- ☐ Abdomen limited (Organ/Quadrant/Abd wall)
- ☐ Abdomen complete with duplex
- ☐ Abdomen limited with duplex
- ☐ Elastography
- ☐ Mesenteric
- ☐ Dialysis graft Doppler
- ☐ Pelvis with Transvaginal (Doppler if needed)
- ☐ Pelvis only (Doppler if needed)
- ☐ Transvaginal only (Doppler if needed)
- ☐ OB < 14 wks (with Transvaginal if Indicated)
- ☐ Renal
- ☐ Renal with Doppler Blood Flow
- ☐ Scrotum (with Ltd Doppler if Needed)
- ☐ Infant Head
- ☐ Infant Hips
- ☐ Shoulder ☐ L ☐ R
- ☐ Venous Doppler Arm ☐ L ☐ R
- ☐ Venous Doppler Leg ☐ L ☐ R
- ☐ Extremity ☐ L ☐ R ☐ Upper ☐ Lower
  Specify site: _____
- ☐ PRP ☐ L ☐ R
  Specify site: _____

BREAST IMAGING

Indicate Location of Abnormality:



- ☐ Screening Mammogram (No Breast Symptoms)
- ☐ Diagnostic Mammogram with US if indicated
- ☐ Contrast Enhanced Mammogram (CEM)
- ☐ Additional Views (Follow Up) with US if indicated
- ☐ Ultrasound Breast ☐ L ☐ R ☐ Implant Integrity
- ☐ Breast Biopsy (Choose One) ☐ L ☐ R
  ☐ **At Radiologist Discretion** ☐ Stereo ☐ US ☐ MRI
- ☐ MRI Breast (Select Below)
  ☐ Implant Integrity ☐ Lesion Detected ☐ Pre-op

Please Choose One:

- ☐ **Radiologist's discretion to determine workup, including contrast and additional imaging if needed**
- ☐ Call my office prior to contrast or additional studies.

DEXA w/ Trabecular Bone Score (TBS)

- ☐ Female Post Menopausal
- ☐ F/U to monitor response to osteoporosis drug therapy.
- ☐ Other Qualifying Reason (ICD Code) If high-risk medications, please also give Primary Diagnosis